

<i>SERFF Tracking Number:</i>	<i>WDMM-126590160</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Woodmen of the World Life Insurance Society</i>	<i>State Tracking Number:</i>	<i>45598</i>
<i>Company Tracking Number:</i>	<i>LIFE APPS 5055 R-3/10, 601 R-3/10, 943 R-3/10, 956 R-3/10, 835 R-3/10, 836 R-3/10, 7692 R-3/10, RATIFICATION 8217 3-10</i>		
<i>TOI:</i>	<i>L08 Life - Other</i>	<i>Sub-TOI:</i>	<i>L08.000 Life - Other</i>
<i>Product Name:</i>	<i>Life App 5050 R-3/10 &amp; Related Forms</i>		
<i>Project Name/Number:</i>	<i>/</i>		

## Filing at a Glance

Company: Woodmen of the World Life Insurance Society

Product Name: Life App 5050 R-3/10 & Related SERFF Tr Num: WDMM-126590160 State: Arkansas

TOI: L08 Life - Other SERFF Status: Closed-Approved-Closed State Tr Num: 45598

Sub-TOI: L08.000 Life - Other Co Tr Num: LIFE APPS 5055 R-3/10, 601 R-3/10, 943 R-3/10, 956 R-3/10, 835 R-3/10, 836 R-3/10, 7692 R-3/10, RATIFICATION 8217 3-10 State Status: Approved-Closed

Filing Type: Form Reviewer(s): Linda Bird  
 Author: Lee Ann Anderson Disposition Date: 05/10/2010  
 Date Submitted: 05/06/2010 Disposition Status: Approved-Closed

Implementation Date Requested: Implementation Date:

State Filing Description:

## General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: These forms are being filed with the Interstate Insurance Product Regulation Commission for use in our domicile state of Nebraska.
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 05/10/2010	Explanation for Other Group Market Type:
	State Status Changed: 05/10/2010
Deemer Date:	Created By: Lee Ann Anderson
Submitted By: Lee Ann Anderson	Corresponding Filing Tracking Number:
Filing Description:	

SERFF Tracking Number: WDM-126590160 State: Arkansas  
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Company Tracking Number: LIFE APPS 5055 R-3/10, 601 R-3/10, 943 R-3/10, 956 R-3/10, 835 R-3/10, 836 R-3/10, 7692 R-3/10, RATIFICATION 8217 3-10  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
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Re: Fraternal Form Filing – Individual Life  
(see list of forms below)

We are submitting the enclosed forms for filing and/or approval. These forms are new and will replace the forms shown below.

Form Number - Form Description - Replaces Form(s) - Approved - SERFF Tracking # - State Tracking #  
5055 R-3/10 - Application for Life Insurance and Membership - 5055 R-9/04 - 11-16-04 - USPH-66ML3V416 - 27902  
601 R-3/10 - Medical Supplementary Statement - 601 R-9/04 - 11-16-04 - USPH-66ML3V416 - 27902  
943 R-3/10 - Administrative Supplementary Statement - 943 R-9/04 - 11-16-04 - USPH-66ML3V416 - 27902  
956 R-3/10 - Underwriting Supplementary Statement - 956 R-9/04 - 11-16-04 - USPH-66ML3V416 - 27902  
835 R-3/10 - Aviation Questionnaire - 835 R-9/04 - 11-16-04 - USPH-66ML3V416 - 27902  
836 R-3/10 - Avocation Questionnaire - 836 R-9/04 - 11-16-04 - USPH-66ML3V416 - 27902  
7692 R-3/10 - Alcohol & Drug Questionnaire - 7692 R-9/04 - 11-16-04 - USPH-66ML3V416 - 27902  
8217 3-10 - Ratification Form - 267-03-0510 - 11-8-05 - USPH-6HLQYL203 - 31041

These forms will be used with life certificates approved by your department. These forms will be produced in both paper and electronic form. The electronic form may have an electronic signature. Individually licensed field representatives will solicit both the paper and electronic forms. The forms are not intended for Internet use.

Application for Life Insurance and Membership Form 5055 R-3/10 is a fully underwritten application which will be used to apply for a new certificate, to reinstate a certificate, and to change an existing certificate. However, only one of these transactions can be done per application form.

Supplementary Statements, Form 601 R-3/10, Form 943 R-3/10, and Form 956 R-3/10 will be used with Application Form 5055 R-3/10. The completion of a supplementary statement is required when, during the underwriting process, it is learned that on the original application an answer to a question was omitted or a question was answered “yes” but details were not given. The applicable proposed insured will be required to complete only the corresponding question(s) on the appropriate supplementary statement. We do not require the completion of the entire form.

Completion of a questionnaire, Form 835 R-3/10, 836 R-3/10, and 7692 R-3/10 is required when on the original application an answer to the aviation, avocation, alcohol or drug question is “yes” and further details need to be gathered to underwrite the application.

Ratification Form 8217 3-10 will be used whenever the applicant requests a change in the application as described in the Statement of Variability for Form 8217 3-10.

The enclosed forms are submitted in final print and are subject to only minor modification in paper stock, ink, border,

SERFF Tracking Number: WDM-126590160 State: Arkansas

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TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other

Product Name: Life App 5050 R-3/10 & Related Forms

Project Name/Number: /

company logo, and adaptation to electronic media and computer printing.

These forms are being filed with the Interstate Insurance Product Regulation Commission for use in our domicile state of Nebraska.

We appreciate your time and consideration. Please contact me if you have any questions concerning this filing.

## Company and Contact

### Filing Contact Information

Lee Ann Anderson, Senior Compliance Analyst landerson@woodmen.org  
 1700 FARNAM STREET 402-661-6206 [Phone]  
 OMAHA, NE 68102 402-449-7732 [FAX]

### Filing Company Information

Woodmen of the World Life Insurance Society	CoCode: 57320	State of Domicile: Nebraska
1700 FARNAM STREET	Group Code:	Company Type:
OMAHA, NE 68102	Group Name:	State ID Number:
(402) 271-7279 ext. [Phone]	FEIN Number: 47-0339250	

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## Filing Fees

Fee Required?	Yes
Fee Amount:	\$400.00
Retaliatory?	No
Fee Explanation:	\$50.00 per form x 8 = \$400.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Woodmen of the World Life Insurance Society	\$400.00	05/06/2010	36281829

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TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Life App 5050 R-3/10 & Related Forms  
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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/10/2010	05/10/2010

*SERFF Tracking Number:*      *WDMM-126590160*      *State:*      *Arkansas*  
*Filing Company:*      *Woodmen of the World Life Insurance Society*      *State Tracking Number:*      *45598*  
*Company Tracking Number:*      *LIFE APPS 5055 R-3/10, 601 R-3/10, 943 R-3/10, 956 R-3/10, 835 R-3/10, 836 R-3/10, 7692 R-3/10, RATIFICATION 8217 3-10*  
*TOI:*      *L08 Life - Other*      *Sub-TOI:*      *L08.000 Life - Other*  
*Product Name:*      *Life App 5050 R-3/10 & Related Forms*  
*Project Name/Number:*      */*

## **Disposition**

Disposition Date: 05/10/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other

Product Name: Life App 5050 R-3/10 & Related Forms

Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Statement of Variability for Ratification 8217 3-10		Yes
Form	Application for Life Insurance and Membership		Yes
Form	Medical Supplementary Statement		Yes
Form	Administrative Supplementary Statement		Yes
Form	Underwriting Supplementary Statement		Yes
Form	Aviation Questionnaire		Yes
Form	Avocation Questionnaire		Yes
Form	Alcohol & Drug Questionnaire		Yes
Form	Ratification Form		Yes

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Product Name: Life App 5050 R-3/10 & Related Forms

Project Name/Number: /

## Form Schedule

### Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	Form 5055 R-3/10	Application/ Enrollment Form	Application for Life Insurance and Membership	Initial		52.300	5055 R-3-10.pdf
	Form 601 R-3/10	Other	Medical Supplementary Statement	Initial		53.600	601 R-3-10.pdf
	Form 943 R-3/10	Other	Administrative Supplementary Statement	Initial		52.600	943 R-3-10.pdf
	Form 956 R-3/10	Other	Underwriting Supplementary Statement	Initial		55.600	956 R-3-10.pdf
	Form 835 R-3/10	Other	Aviation Questionnaire	Initial		63.700	835 R-3-10.pdf
	Form 836 R-3/10	Other	Avocation Questionnaire	Initial		50.800	836 R-3-10.pdf
	Form 7692 R-3/10	Other	Alcohol & Drug Questionnaire	Initial		66.700	7692 R-3-10.pdf
	Form 8217 3-10	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Ratification Form	Initial		61.300	8217 3-10 Ratification.pdf

**WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY**  
**1700 Farnam Street Omaha, Nebraska 68102**

**APPLICATION FOR INDIVIDUAL  
LIFE INSURANCE AND  
MEMBERSHIP**

New Certificate Number:  This Change to Affect Certificate Number:

Field Representative Code: 123456 ☒ New Certificate ☐ Reinstatement ☐ Change Existing Certificate ☐ Term Conversion

**1 PROPOSED INSURED (The insured is the applicant owner unless otherwise designated in Section 3.)**

First	Middle Initial	Last	Suffix	Social Security Number
John	K	Woodmen		123-45-6789

Street Address (Residence of Proposed Insured)	Apt./Unit #
1234 Main Street	

City	State	Zip
Omaha	NE	68102

☒ Mailing Address is the same as above Street Address

Mailing Address if Different from Residence	City	State	Zip

Sex	Date of Birth (MM/DD/YYYY)	Age Now	Rating Age	Birth State/Country	Telephone Day	(402) 231-1234
M	11/01/1974	35	35	NE	Eve	(402) 123-4321

**2 PROPOSED ADULT APPLICANT (Complete only if proposed insured is age 0 - 15.)**

First	Middle Initial	Last	Suffix	Social Security Number

Street Address (Residence of Proposed Adult Applicant)	Apt./Unit #

City	State	Zip	Occupation and Duties

☐ Mailing Address is the same as above Street Address

Mailing Address if Different from Residence	City	State	Zip

Sex	Date of Birth (MM/DD/YYYY)	Telephone Day	Eve	Relationship to Proposed Insured (If Legal Guardian, submit copy of Letters of Guardianship)

**OWNERSHIP TYPE If no ownership type is checked, the proposed adult applicant will be the controller of the certificate.**

☐ **PROPOSED ADULT APPLICANT IS CONTROLLER** - The youth insured will be the owner of the certificate. The adult applicant will retain control over the certificate until the youth insured reaches the age of majority. The applicant controller can exercise all rights in the certificate, except for the right of assignment, on behalf of the youth insured until the youth insured reaches the age of majority.

☐ **PROPOSED ADULT APPLICANT IS OWNER** - The adult applicant will be the owner of the certificate. The adult applicant will have the right to exercise all rights in the certificate.

**3 PROPOSED APPLICANT OWNER (Complete only if different than proposed insured. Not applicable if the proposed insured is age 0-15.)**

Owner is: ☐ Individual, different than proposed insured ☐ Partnership ☐ Corporation ☐ Trust ☐ Other

Name	Social Security No./Tax ID No.

Street Address (Residence if Individual)	Apt./Unit #	State & Date of Trust/Corporation/Partnership
		Mo. Day Year

City	State	Zip

☐ Mailing Address is the same as above Street Address

Mailing Address if Different from Street Address	City	State	Zip

Sex	Date of Birth (MM/DD/YYYY)	Telephone Day	Eve	Relationship to Proposed Insured



**4 PROPOSED JOINT APPLICANT OWNER** (Complete only if different than proposed insured. Not applicable if the proposed insured is age 0-15.)

Joint Owner is: ☐ Individual, different than proposed insured ☐ Partnership ☐ Corporation ☐ Trust ☐ Other

Name \_\_\_\_\_ Social Security No./Tax ID No. \_\_\_\_\_

Street Address (Residence if Individual) \_\_\_\_\_ Apt./Unit # \_\_\_\_\_ State & Date of Trust/Corporation/Partnership \_\_\_\_\_

Mo. \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

☐ Mailing Address is the same as above Street Address

Mailing Address if Different from Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex	Date of Birth (MM/DD/YYYY)	Telephone Day Eve	Relationship to Proposed Insured
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☐ Check here if more than two owners. Complete a Supplementary Statement for additional owners.

**5 LODGE MEMBERSHIP (Applies to proposed insured.)**

A. ☒ New Member

B. ☐ Current Member - No Lodge Change

C. ☐ Current Member - New Lodge Number \_\_\_\_\_ State \_\_\_\_\_ (Do Not Transfer Existing Certificates)

D. ☐ Current Member - New Lodge Number \_\_\_\_\_ State \_\_\_\_\_ (Transfer All Existing Certificates)

**6 TYPE OF CHANGE OR TERM CONVERSION**

Certificate Number(s) to change or convert: \_\_\_\_\_

**CONVERSION**

☐ Convert \$ \_\_\_\_\_ of certificate or rider ☐ Retain \$ \_\_\_\_\_ as term insurance

☐ Exercise Additional Insurance Option/Guaranteed Insurability Rider option

Note: Flexible Life increases **ONLY** available as a result of AIO Rider attached to Flexible Life.

☐ Convert to a new product

☐ Increase existing Adjustable Life certificate number \_\_\_\_\_ BY \$ \_\_\_\_\_

☐ Increase existing Adjustable Life certificate number \_\_\_\_\_ so that the **total face amount** will be \$ \_\_\_\_\_

**CHANGE**

☐ 90 day change

☐ Consider for possible rate reduction/removal

☐ Consider for non-tobacco classification

☐ Decrease **TO** \$ \_\_\_\_\_

☐ Purchase paid-up insurance with refunds on deposit

☐ Increase existing Adjustable Life certificate number \_\_\_\_\_ BY \$ \_\_\_\_\_

☐ Increase existing Adjustable Life certificate number \_\_\_\_\_ so that the **total face amount** will be \$ \_\_\_\_\_

☐ Change from Exclude to Include (Adjustable Life & Flexible Life only)

☐ Change from Include to Exclude (Adjustable Life & Flexible Life only)

## 7 LIFE INSURANCE

Kind of Basic Certificate Applied For:	No Lapse GUAR UL (NLGUL)	Amount	\$
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**Adjustable Life & Flexible Life Only (Choose One)** ☐ Include Cash Value ☐ Exclude Cash Value

**For No Lapse Guarantee Universal Life Only**

Planned Premium payable to certificate anniversary following age: **(Choose One)** ☒ 80 ☐ 100 ☐ 120

## BENEFITS & RIDERS

Additional Insurance Option/Guaranteed Insurability Rider . . . . . ☐ Add Amount \$ \_\_\_\_\_  
(Not available for No Lapse Guarantee Universal Life) ☐ Reduce TO Amount \$ \_\_\_\_\_

☐ Reduce **TO** Amount \$ \_\_\_\_\_

☐ Remove

Accidental Death Benefit Rider (Amount calculated by the Home Office). . ☐ Add Amount \$

☐ Reduce **TO** Amount \$☐ Remove

Disability Income Rider . . . . . ☐ Reduce **TO** Amount \$

☐ Remove

Accelerated Benefit Rider (included unless "No" checked here) . . . . . ☐ No ☐ Add ☐ Remove

☐ No☐ Add☐ Remove

Applicant Waiver Rider . . . . . ☐ Add ☐ Remove  
(Youth Applications Only - Proposed Insured Age 0-15)

☐ Add☐ Remove

**Applicant's Certificate Number** **Applicant must be a member of Woodmen and age 16-55.**

A. Is the applicant currently working at least 30 hours per week and performing his/her regular duties of employment? ☐ Yes ☐ No  
If "No", give details.

B. Has the applicant ever filed for disability benefits or ever been compensated for a disabling condition? . . . . . ☐ Yes ☐ No  
If "Yes", give details.

C. Is the applicant currently taking any medications? . . . . . ☐ Yes ☐ No  
If "Yes", state name of drug and condition requiring it.

**ADDITIONAL BENEFITS & RIDERS AVAILABLE FOR TRADITIONAL LIFE ONLY**

Kind of Term Rider: \_\_\_\_\_ . . . . ☐ Add Amount \$

☐ Reduce **TO** Amount \$☐ Remove

Waiver of Premium Rider . . . . . ☐ Add ☐ Remove

☐ Add☐ Remove

Automatic Premium Loan Provision . . . . . ☐ Add ☐ Remove

☐ Add☐ Remove**ADDITIONAL BENEFITS & RIDERS AVAILABLE FOR UNIVERSAL LIFE ONLY**

Waiver of Monthly Deduction Rider . . . . . ☐ Add ☐ Remove

☐ Add☐ Remove

2X Waiver of Monthly Deduction Rider . . . . . ☐ Remove

☐ Remove

Cost of Living Adjustment Rider . . . . . ☐ Remove

☐ Remove

### Waiver of Premium Rider on Adjustable Life Increases only

(original certificate must be issued prior to 9/88) . . . . . ☐ Add ☐ Remove

Add

☐ Remove

**8 REFUND OPTION**

Unless specifically stated otherwise in your contract, if no option, more than one option, or an unavailable option is checked, refunds will be:

- left with Woodmen at interest on renewable Term and No Lapse Guarantee Universal Life
- used to buy paid-up additions on Whole Life and Youth Term, or
- used as additional premium on Adjustable Life and Flexible Life

Available for Traditional Life Only	Available for Adjustable Life & Flexible Life Only	Available for No Lapse Guarantee Universal Life Only
<input type="checkbox"/> Cash <input type="checkbox"/> Paid-up additions <input type="checkbox"/> Left with Woodmen at interest <input type="checkbox"/> Apply to reduce annual premium (Not available with Pre-Authorized Collection)	<input type="checkbox"/> Cash <input type="checkbox"/> Used as Additional Premium For Adjustable Life and Flexible Life, after maximum cash value (Choose One): <input type="checkbox"/> Paid in cash <input type="checkbox"/> Used to purchase additional insurance <input type="checkbox"/> Left with Woodmen at interest	<input type="checkbox"/> Cash <input checked="" type="checkbox"/> Left with Woodmen at interest

**9 BENEFICIARY**

- ◆ For **reinstatements, changes and increases in face amounts**: Completion of this section will revoke all previous beneficiary designations for this certificate.
- ◆ For **term conversions**: Completion of this section will apply only to the new certificate issued as a result of this application. Previous beneficiary designations for any existing certificate or any portion of existing certificate(s) not converted as a result of this application will remain in effect and will not be revoked. If the beneficiary is to be changed for any existing certificate(s), please submit Beneficiary Change Form 181.
- ◆ For **Additional Insurance Option/Guaranteed Insurability Rider** option exercised to increase the face amount: Completion of this section will revoke all previous beneficiary designations for this certificate.
- ◆ For **new certificate issued as a result of exercising Additional Insurance Option/Guaranteed Insurability Rider** option: Completion of this section will apply to the new certificate only. Previous beneficiary designations for any existing certificate(s) will remain in effect and will not be revoked. If the beneficiary is to be changed for any existing certificate(s), please submit Beneficiary Change Form 181.

**PRIMARY BENEFICIARY**

Name	City	State	Relationship	Age or Date of Birth	Social Security No./ Tax ID Number
Joseph Woodmen	Omaha	NE	Brother	45	123-66-6866

**ALTERNATE BENEFICIARY**

Name	City	State	Relationship	Age or Date of Birth	Social Security No./ Tax ID Number
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**UNLESS OTHERWISE STATED IN WRITING, THE FOLLOWING CONDITIONS APPLY**

- The death benefit, when paid to all surviving primary beneficiaries, is paid equally in one sum.
- If there are no surviving primary beneficiaries, the death benefit is paid equally in one sum to all surviving alternate beneficiaries.
- The beneficiary will have the right to change the method by which the death benefit is paid after the death of the insured.

**10 TOBACCO USAGE (Applies to proposed insured age 18 and over.)**

PartII\_Setup: off

In the past **12 months**, has the proposed insured used tobacco/nicotine in any form, such as cigarettes, pipes, cigars, snuff or chewing tobacco OR smoking cessation products such as nicotine patches or nicorette gum? . . . . . ☐ Yes ☒ No

A. If "Yes", indicate date last used: mo. \_\_\_\_\_ yr. \_\_\_\_\_ Indicate form(s) used: \_\_\_\_\_  
If cigarettes, how many packs per day? \_\_\_\_\_ If cigars, indicate quantity and frequency: \_\_\_\_\_

B. If "No", has the proposed insured used tobacco/nicotine in any form OR smoking cessation products in the last **36 months**? . . . . . ☐ Yes ☒ No

**11 OCCUPATION (Applies to proposed insured age 16 and over.)**

Occupation and Duties Teacher	Annual Income (Nearest \$10,000) 50,000	How Long in Present Occupation? 10y
Name of Employer and Nature of Business ABC High School	Address of Business 123 Education Street	Previous Occupation

**12 NONMEDICAL (Applies to proposed insured age 14 and over.)**

A. Does the proposed insured have a current driver's license/permit?

☐ No, explain why no license/permit: \_\_\_\_\_

☒ Yes, Driver's License/Permit Number: 234567 State: NE

B. Is the proposed insured currently a United States citizen? If "No", provide permanent resident card number: ☒ Yes ☐ No

C. Has the proposed insured ever had a license/permit suspended or revoked? . . . . . ☐ Yes ☒ No

D. Has the proposed insured had any moving traffic violations or traffic accidents within the past three years? . . ☐ Yes ☒ No

E. Has the proposed insured been convicted of or pled guilty or no contest to driving while intoxicated or under the influence of a narcotic drug? . . . . . ☐ Yes ☒ No

F. Has the proposed insured been convicted of or pled guilty or no contest to a crime within the past 10 years, or is the proposed insured currently awaiting trial for any crime? . . . . . ☐ Yes ☒ No

G. Is the proposed insured currently on probation or parole? . . . . . ☐ Yes ☒ No

H. Is the proposed insured a member of the U.S. Armed Services or active reserve? . . . . . ☐ Yes ☒ No

If "Yes", has the proposed insured been alerted of possible deployment? If "Yes", give details below. . . . . ☐ Yes ☐ No

**If any question C-H has been answered "Yes", give dates and full details.**

I. Within the next 12 months, does the proposed insured intend to travel or reside outside of the U.S., Canada or any U.S. territories? If "Yes", submit details on Form 956. . . . . ☐ Yes ☒ No

J. In the past 3 years has the proposed insured participated in aviation as a pilot, crew member or student – to include sky diving, hang gliding, ballooning, ultralight, and other sky sports – or intends to within the next 2 years? If "Yes", submit an Aviation Questionnaire. . . . . ☐ Yes ☒ No

K. In the past 3 years has the proposed insured participated in racing of any type, skin or scuba diving, boxing, ultimate fighting or mountain climbing – or intends to within the next 2 years? If "Yes", submit an Avocation Questionnaire . . . . . ☐ Yes ☒ No

**13 YOUTH INFORMATION (Applies to proposed insured age 0-15.)**

A. Does the child live with the natural or adoptive parent(s)? If "No", explain why . . . . . ☐ Yes ☐ No

B. Does the child have brothers and/or sisters? ☐ Yes ☐ No (If "Yes", indicate amount of coverage carried on each child and their ages.)

C. Indicate amount of insurance carried by Father \$ \_\_\_\_\_  
Indicate amount of insurance carried by Mother \$ \_\_\_\_\_

1. Physician or medical facility that has the proposed insured's most complete and current medical records:
- Dr. Thomas Shepard

(402) 322-3241
- Physician/Facility Name

Phone Number
- 111 Medical Street

Omaha

NE

68102
- Address

City

State

Zip
- Date Last Seen

10/15/2009

Reason For Visit

Annual Check-up
2. Has the proposed insured had or ever been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for any disease or disorder of the:
- YES

NO
- A. Brain or Nervous System – such as epilepsy, paralysis or mental illness – to include treatment or counseling for depression or anxiety? . . . . . A.
- ☐

☒
- B. Respiratory System – such as emphysema, bronchitis, asthma or sleep apnea– to include disorders of the eyes, ears, nose or throat? . . . . . B.
- ☐

☒
- C. Circulatory System – such as high blood pressure, chest pain, heart attack, heart surgery, heart murmur, stroke, or phlebitis? . . . . . C.
- ☐

☒
- D. Digestive or Urinary Tract Systems – such as ulcer, colitis, hepatitis, kidney infection, kidney stones, protein, blood or sugar in the urine – to include diabetes and thyroid disorders? . . . . . D.
- ☐

☒
- E. Musculoskeletal System – such as arthritis, gout, back disorders, or any connective tissue disorders? . . . . . E.
- ☐

☒
- F. Reproductive System – such as prostate, testes, breasts, ovaries or uterus disorders? . . . . . F.
- ☐

☒
- G. Immune System – such as lupus, multiple sclerosis or scleroderma except those related to the Human Immunodeficiency Virus?. . . . . G.
- ☐

☒
3. Has the proposed insured ever:
- A. Been diagnosed or treated for cancer or tumor of any kind? . . . . . A.
- ☐

☒
- B. Had or been advised to have any surgical operation? . . . . . B.
- ☐

☒
- C. Been treated or received counseling for alcohol use, alcoholism or drug addiction? If "Yes", submit an Alcohol & Drug Questionnaire . . . . . C.
- ☐

☒
- D. Used narcotics, barbiturates, excitant drugs, hallucinogens or tranquilizers without a prescription by a physician? If "Yes", submit an Alcohol & Drug Questionnaire . . . . . D.
- ☐

☒
4. Has the proposed insured been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS Virus) or Acquired Immune Deficiency Syndrome (AIDS)? . . . . . 4.
- ☐

☒
5. At any time in the past five years, has the proposed insured been treated or diagnosed by a medical professional with any other illness or injury not mentioned above? . . . . . 5.
- ☐

☒
6. During the past five years has the proposed insured:
- A. Consulted, been examined by, treated by or received diagnostic tests (e.g., X-rays, ECG, or blood studies except those tests related to the Human Immunodeficiency Virus (AIDS Virus)) from a physician, hospital, clinic or similar institution? . . . . . A.
- ☐

☒
- B. Received a pension, applied for or been compensated for disability? If "Yes", please explain . . . . . B.
- ☐

☒
- C. Had an application for life, health, accident or disability insurance declined, postponed, rated up or modified? If "Yes", please explain what action was taken and why . . . . . C.
- ☐

☒
7. Does the proposed insured take medication, use medical assistive devices or equipment (e.g. CPAP, oxygen)? If "Yes", state the name of the drug or describe the device and condition requiring it. . . . . 7.
- ☐

☒
8. Is the proposed insured now pregnant? If "Yes", indicate due date and any complications. . . . . 8.
- ☐

☐
9. A. Proposed Insured's Height: 6 ft. 0 in. Weight: 210 lbs.
- B. Has weight changed more than 15 pounds in the past year? If "Yes", indicate how much and by what means: B.
- ☐

☒

## 14 MEDICAL, Continued

If any question 2-8 has been answered "Yes", give full details below:

Question Number	Diagnosis	Treatment/ Medication	Dates From/To	Name, Address & Phone Number Of Health Care Professional/Facility

If more space is needed for Medical details, include an additional page, signed and dated.

## 15 FAMILY HISTORY (Applies to proposed insured.)

- A. Has a parent or sibling been diagnosed or treated by a member of the medical profession for cardiovascular disease or cancer prior to age 60? . . . . . ☐ Yes ☒ No

If "Yes", give details \_\_\_\_\_

- B. Did death of a parent or sibling occur prior to age 60 due to cardiovascular disease or cancer? . . . . . ☐ Yes ☒ No

## 16 REPLACEMENT The proposed applicant is the insured, unless an adult applicant (youth application) or an owner other than the proposed insured is designated. Submit replacement forms, if required.

- A. Does the proposed applicant have any existing life insurance or annuity contracts? . . . . . ☐ Yes ☒ No
- B. Will any existing life or annuity contracts be replaced if the proposed certificate is issued? . . . . . ☐ Yes ☒ No
- C. Will a 1035 exchange be involved? (If "Yes", submit Form 1035 for companies other than Woodmen.) . . . . ☐ Yes ☒ No
- If B or C is answered "Yes", provide policy number and company information below for the policy being replaced.

Policy Number	Company Name	Address	City	State	Zip

## 17 INSURANCE NOW IN FORCE OR APPLIED FOR

List all policies currently in force or applied for on the **proposed insured** not described in Section 16. **If none, check here.** ☒

Company Name	Policy Number	Kind	Life Insurance Amount	Accidental Death Amount	Year Issued

**18 PREMIUM DEPOSIT**

- ☐ 1. Cash/Cash Equivalent Amount: \$ \_\_\_\_\_ (Submit Cash Receipt)
- ☐ 2. Refunds on Deposit Amount: \$ \_\_\_\_\_
- ☐ 3. Cash Surrender Value Amount: \$ \_\_\_\_\_
- ☒ 4. Check Amount: \$ 100.00
- ☐ 5. Credit Card Amount: \$ \_\_\_\_\_
- ☐ 6. Express Check Amount: \$ \_\_\_\_\_
- ☐ 7. No Premium Deposit Has Been Made
- Total Amount To Be Applied: \$ 100.00 Premium and \$ 12.00 Fraternal Dues As Payment for 12 Months.

Payor Name: \_\_\_\_\_ Relationship to Proposed Insured: \_\_\_\_\_

If 1-6 is selected on an application for a new certificate, give conditional receipt to applicant; if 2, 3, 5 or 6 is selected, also submit proper authorization.

P.A.C. authorizations, List Bill, and 1035 exchange requests to companies other than Woodmen are NOT premium deposits for RECEIPT AND CONDITIONAL INSURANCE AGREEMENT purposes.

**Advance Premiums:** \$ \_\_\_\_\_ No future payments until advance premium depleted.

☐ Max Out at issue for Adjustable Life & Flexible Life only

**For Conversions Only** — Any credits should be applied as follows:

☐ Additional Premium for Traditional Life ☐ Premium for Universal Life ☐ Refund any credits

**19 FOR ADJUSTABLE LIFE & FLEXIBLE LIFE ONLY**

If the premium paid at issue or at any time thereafter would cause the certificate to be classified as a modified endowment contract (MEC) because the premium exceeds the amount allowed by the Internal Revenue Code (IRC), I choose one of the following:

- ☐ Allow the certificate to become a MEC (excess premium is added to the certificate's cash value).
- ☐ Not allow the certificate to become a MEC by placing the excess premium paid at issue or at any time thereafter into an advance premium fund that earns interest. Interest earned will be reported annually to the IRS. Woodmen is authorized to automatically transfer money from the advanced premium fund to the certificate's cash value once a year. The amount transferred each year will not exceed the amount allowed by the IRC based on Woodmen's understanding of the requirements of the IRC.

**20 FUTURE BILLING**

Billing Method		Frequency
<input checked="" type="checkbox"/> New P.A.C. plan *	<input type="checkbox"/> Do Not Send Future Billing	<input type="checkbox"/> Annually
<input type="checkbox"/> Add to present P.A.C. plan (list one certificate number currently being paid on plan)	<input type="checkbox"/> Direct Bill	<input checked="" type="checkbox"/> Semiannually
<b>P.A.C. billing not available with refund option</b>	<input type="checkbox"/> Government Allotment (Military)	<input type="checkbox"/> Quarterly
<b>Apply To Reduce Annual Premium</b>	<input type="checkbox"/> List Bill *	<input type="checkbox"/> Monthly
CERTIFICATE NO. _____	Group Number: _____	
Payor's Name: _____	* Submit proper authorizations	
Bank Acct. No.: _____		

**For Universal Life Only**

Planned Premium, excluding fraternal dues for selected frequency: \$ 100.00

**21 PAYOR INFORMATION**

☒ Proposed Insured ☐ Adult Applicant ☐ Applicant Owner ☐ Joint Applicant Owner ☐ Other (Complete below)

First Middle Initial Last Suffix

Address Apt/Unit #

City State Zip

Relationship to Proposed Insured Date of Birth (MM/DD/YYYY) Social Security Number

**22 PARENT OR LEGAL GUARDIAN'S CONSENT****(To be completed ONLY when the proposed adult applicant is not a parent or legal guardian.)**

I, the parent or legal guardian, give my consent to this application on the child's life and the beneficiaries as designated.

I have received a copy of the "Notice Relating to the MIB (Medical Information Bureau)", "Notice Required Under the Fair Credit Reporting Act" and if applicable the "Notice of Information Practices".

**Certification Instructions** – You must cross out the language in item (2) within this box if the child has been notified by the IRS that the child is currently subject to backup withholding because of underreporting interest or dividends on a tax return.

Under penalties of perjury, I, the undersigned parent or legal guardian, certify:

- (1) the number shown on this application represents the correct Taxpayer Identification Number (TIN) of the proposed insured child AND
- (2) the same is not subject to backup withholding because: (a) the child is exempt from backup withholding, or (b) the child has not been notified by the IRS that he/she is subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified the child that he/she is no longer subject to backup withholding, AND
- (3) the child is a United States person (including a United States resident alien).

**The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to the Proposed Insured  
(If Legal Guardian, submit copy of  
Letters of Guardianship)

**23 ACKNOWLEDGEMENT AND AGREEMENT**

The following statements must be read by or to the proposed insured and any proposed applicant owner or the proposed adult applicant:

I have received a copy of the "Notice Relating to the MIB (Medical Information Bureau)", "Notice Required Under the Fair Credit Reporting Act" and if applicable the "Notice of Information Practices".

The Accelerated Death Benefit Disclosure Statement has been given to me, the applicant owner, if applicable.

I have read this application. I represent that each of the answers and the information given therein is full, complete and true, to the best of my knowledge and belief, with the understanding that they shall be considered as representations and not warranties. I agree as follows:

1. Notice to or knowledge of any Field Representative or medical examiner as to information which relates to the proposed insured will not be notice to Woodmen unless it is in writing in this application.
2. Field Representatives do not have authority to (a) determine insurability; (b) change any terms of this application; (c) make or change a contract for Woodmen; (d) waive any rights or requirements of Woodmen. I understand that oral statements between the Field Representative and myself regarding such matters of limited authority are not binding on Woodmen unless accepted by Woodmen in writing.

I agree to be bound by the terms of this application and the life insurance certificate for which I am applying. I also agree to be bound by all obligations set forth in Woodmen's Articles of Incorporation and its Constitution and Laws and I acknowledge Woodmen's common bond and purpose.

**Applications for New Certificate:**

Except for coverage which may be provided in the RECEIPT AND CONDITIONAL INSURANCE AGREEMENT, no insurance will be in force because of this application until it has been approved and at least one monthly premium has been paid to Woodmen.

**Applications for Reinstatement, Change to Existing Certificate, or Term Conversion:**

I agree this application shall not be construed as extending temporary insurance coverage on the life of the proposed insured. Reinstatement of or change to existing insurance will be effective and coverage will commence on the date this application is approved in the Home Office of Woodmen.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.



- (1) the number(s) shown on this application represents my (and/or the child's) correct Taxpayer Identification Number (TIN) AND
- (2) I (and/or the child) am not subject to backup withholding because: (a) I (and/or the child) am exempt from backup withholding, or (b) I (and/or the child) have not been notified by the IRS that I (and/or the child) am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me (and/or the child) that I (and/or the child) am no longer subject to backup withholding, AND
- (3) I (and/or the child) am a United States person (including a United States resident alien).

☐ By checking this box, I the proposed applicant, acknowledge this application was signed in a different state than the state in which I reside.

Signature of Proposed Applicant Owner if not Proposed Insured & Title if Trust/Corporation/Partnership	Date
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Signature of Proposed Joint Applicant Owner & Title if Trust/Corporation/Partnership	Date
---	------

**24 FIELD REPRESENTATIVE'S CERTIFICATION** The proposed applicant is the insured, unless an adult applicant (youth application) or an owner other than the proposed insured is designated. Submit replacement forms, if required.

- |                   |       |       |   |
|-------------------|-------|-------|---|
| Primary FR Code   | _____ | _____ | % |
| Secondary FR Code | _____ | _____ | % |
| Third FR Code     |       |       | % |

Thomas K Smith

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Field Representative's Name Printed

☒ **WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY**  
☐ **OMAHA WOODMEN LIFE INSURANCE SOCIETY**  
**1700 Farnam Street Omaha, Nebraska 68102**

CERTIFICATE NUMBER

MEDICAL  
SUPPLEMENTARY  
STATEMENT

☒ New Certificate ☐ Change Existing Certificate

☐ Reinstatement ☐ Term Conversion

Field Representative Code: 123456

**PROPOSED INSURED (The insured is the applicant owner unless otherwise designated.)**

First	Middle Initial	Last	Suffix
John	K	Woodmen	

Date of Birth (MM/DD/YYYY)

11/01/1974

Social Security Number

123-45-6789

**MEDICAL** Applies to proposed insured. If proposed insured is age 0-15, questions 1 through 9 are to be answered by whoever has the best knowledge of the child's health history. (Usually the person with whom the child resides.)

1. **Physician or medical facility that has the proposed insured's most complete and current medical records:**

Physician/Facility Name		Phone Number	
Address	City	State	Zip
Date Last Seen		Reason For Visit	

2. **Has the proposed insured had or ever been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for any disease or disorder of the:**

YES NO

- A. Brain or Nervous System – such as epilepsy, paralysis or mental illness – to include treatment or counseling for depression or anxiety? . . . . . A. ☐ ☐
- B. Respiratory System – such as emphysema, bronchitis, asthma or sleep apnea – to include disorders of the eyes, ears, nose or throat? . . . . . B. ☐ ☐
- C. Circulatory System – such as high blood pressure, chest pain, heart attack, heart surgery, heart murmur, stroke, or phlebitis? . . . . . C. ☐ ☐
- D. Digestive or Urinary Tract Systems – such as ulcer, colitis, hepatitis, kidney infection, kidney stones, protein, blood or sugar in the urine – to include diabetes and thyroid disorders? . . . . . D. ☐ ☐
- E. Musculoskeletal System – such as arthritis, gout, back disorders, or any connective tissue disorders? . . . . . E. ☐ ☐
- F. Reproductive System – such as prostate, testes, breasts, ovaries or uterus disorders? . . . . . F. ☐ ☐
- G. Immune System – such as lupus, multiple sclerosis or scleroderma except those related to the Human Immunodeficiency virus? . . . . . G. ☐ ☐

3. **Has the proposed insured ever:**

- A. Been diagnosed or treated for cancer or tumor of any kind? . . . . . A. ☐ ☒
- B. Had or been advised to have any surgical operation? . . . . . B. ☐ ☐
- C. Been treated or received counseling for alcohol use, alcoholism or drug addiction? If "Yes", submit an Alcohol & Drug Questionnaire . . . . . C. ☐ ☐
- D. Used narcotics, barbiturates, excitant drugs, hallucinogens or tranquilizers without a prescription by a physician? If "Yes", submit an Alcohol & Drug Questionnaire . . . . . D. ☐ ☐

4. **Has the proposed insured been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?** . . . . . 4. ☐ ☐

5. **At any time in the past five years, has the proposed insured been treated or diagnosed by a medical professional with any other illness or injury not mentioned above?** . . . . . 5. ☐ ☐

6. **During the past five years has the proposed insured:**

- A. Consulted, been examined by, treated by or received diagnostic tests (e.g., X-rays, ECG, or blood studies except those tests related to the Human Immunodeficiency Virus (AIDS Virus)) from a physician, hospital, clinic or similar institution? . . . . . A. ☐ ☐
- B. Received a pension, applied for or been compensated for disability? If "Yes", please explain. . . . . B. ☐ ☐
- C. Had an application for life, health, accident or disability insurance declined, postponed, rated up or modified? If "Yes", please explain what action was taken and why . . . . . C. ☐ ☐

7. **Does the proposed insured take medication, use medical assistive devices or equipment (e.g. CPAP, oxygen)?** If "Yes", state the name of the drug or describe the device and condition requiring it. . . . . 7. ☐ ☐
8. **Is the proposed insured now pregnant?** If "Yes", indicate due date and any complications. . . . . 8. ☐ ☐
9. A. **Proposed Insured's Height:** \_\_\_\_\_ ft. \_\_\_\_\_ in. **Weight:** \_\_\_\_\_ lbs.
- B. Has weight changed more than 15 pounds in the past year? If "Yes", indicate how much and by what means: B. ☐ ☐

**If any question 2-8 has been answered "Yes", give full details below:**

Question Number	Diagnosis	Treatment/ Medication	Dates From/To	Name, Address & Phone Number Of Health Care Professional/Facility

If more space is needed for Medical details, include an additional page, signed and dated.

**I have read the answers written above. I ratify and agree to be bound by such answers and agree that they are true and complete to the best of my knowledge and belief. I agree they shall form part of this application.**

*John K Woodmen*

Signature of Proposed Insured,  
if age 16 or older OR

Signature of Proposed Adult Applicant

04/01/2010

Date

<input checked="" type="checkbox"/> <b>WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY</b> <input type="checkbox"/> <b>OMAHA WOODMEN LIFE INSURANCE SOCIETY</b> <b>1700 Farnam Street      Omaha, Nebraska      68102</b>			<b>CERTIFICATE NUMBER</b> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>		<b>ADMINISTRATIVE SUPPLEMENTARY STATEMENT</b>	
Field Representative Code: <u>123456</u>			<input checked="" type="checkbox"/> New Certificate <input type="checkbox"/> Change Existing Certificate <input type="checkbox"/> Reinstatement <input type="checkbox"/> Term Conversion			

**PROPOSED INSURED (The insured is the applicant owner unless otherwise designated.)** off

First John	Middle Initial K	Last Woodmen	Suffix
---------------	---------------------	-----------------	--------

Date of Birth (MM/DD/YYYY) 11/01/1974	Social Security Number 123-45-6789
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**1 CLARIFICATION OF PROPOSED INSURED'S NAME**

Please provide the correct full name.

First John	Middle Initial K	Last Woodmen	Suffix
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**2 CLARIFICATION OF PROPOSED APPLICANT'S NAME**

The proposed applicant's name on the application and the signature differ. Please print your correct name.

First	Middle Initial	Last	Suffix
-------	----------------	------	--------

**3 PROPOSED ADULT APPLICANT (Complete only if proposed insured is age 0 - 15.)**

First	Middle Initial	Last	Suffix	Social Security Number
-------	----------------	------	--------	------------------------

Street Address (Residence of Proposed Adult Applicant) Apt/Unit #

City	State	Zip	Occupation and Duties   Relationship to Proposed Insured (If Legal Guardian, submit copy of Letters of Guardianship)
<input type="checkbox"/> Mailing Address is the same as above Street Address			
Mailing Address if Different from Residence	City	State      Zip	

Sex	Date of Birth (MM/DD/YYYY)	Telephone Day Eve	
-----	----------------------------	----------------------	--

**OWNERSHIP TYPE** If no ownership type is checked, the proposed adult applicant will be the controller of the certificate.

☐ **PROPOSED ADULT APPLICANT IS CONTROLLER** - The youth insured will be the owner of the certificate. The adult applicant will retain control over the certificate until the youth insured reaches the age of majority. The applicant controller can exercise all rights in the certificate, except for the right of assignment, on behalf of the youth insured until the youth insured reaches the age of majority.

☐ **PROPOSED ADULT APPLICANT IS OWNER** - The adult applicant will be the owner of the certificate. The adult applicant will have the right to exercise all rights in the certificate.

**4 PROPOSED JOINT APPLICANT OWNER (Complete only if different than proposed insured. Not applicable if the proposed insured is age 0-15.)**

Joint Owner is:    ☐ Individual, different than proposed insured    ☐ Partnership    ☐ Corporation    ☐ Trust    ☐ Other

Name	Social Security No./Tax ID No.
------	--------------------------------

Street Address (Residence if Individual)	Apt./Unit #	State & Date of Trust/Corporation/Partnership
		Mo.      Day      Year

City	State	Zip
------	-------	-----

☐ Mailing Address is the same as above Street Address

Mailing Address if Different from Street Address	City	State	Zip
--	------	-------	-----

Sex	Date of Birth (MM/DD/YYYY)	Telephone Day Eve	Relationship to Proposed Insured
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**4 PROPOSED JOINT APPLICANT OWNER, (Continued)**

Joint Owner is: ☐ Individual, different than proposed insured ☐ Partnership ☐ Corporation ☐ Trust ☐ Other

Name \_\_\_\_\_ Social Security No./Tax ID No. \_\_\_\_\_

Street Address (Residence if Individual) \_\_\_\_\_ Apt./Unit # \_\_\_\_\_ State & Date of Trust/Corporation/Partnership \_\_\_\_\_  
 Mo. \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

☐ Mailing Address is the same as above Street Address

Mailing Address if Different from Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex	Date of Birth (MM/DD/YYYY)	Telephone Day Even	Relationship to Proposed Insured

**5 APPLICANT WAIVER RIDER (Youth Applications Only - Proposed Insured Age 0-15)**

Applicant Waiver Rider . . . . . ☐ Add ☐ Remove

Applicant's Certificate Number: \_\_\_\_\_ **Applicant must be a member of Woodmen and age 16-55.**

A. Is the applicant currently working at least 30 hours per week and performing his/her regular duties of employment? ☐ Yes ☐ No  
 If "No", give details. \_\_\_\_\_

B. Has the applicant ever filed for disability benefits or ever been compensated for a disabling condition? . . . . . ☐ Yes ☐ No  
 If "Yes", give details. \_\_\_\_\_

C. Is the applicant currently taking any medications? . . . . . ☐ Yes ☐ No  
 If "Yes", state name of drug and condition requiring it. \_\_\_\_\_

**6 REPLACEMENT** The proposed applicant is the insured, unless an adult applicant (youth application) or an owner other than the proposed insured is designated. Submit replacement forms, if required.

- A. Does the proposed applicant have any existing life insurance or annuity contracts? . . . . . ☐ Yes ☐ No
- B. Will any existing life or annuity contracts be replaced if the proposed certificate is issued? . . . . . ☐ Yes ☐ No
- C. Will a 1035 exchange be involved? (If "Yes", submit Form 1035 for companies other than Woodmen.) . . . . . ☐ Yes ☐ No
- If B or C is answered "Yes", provide policy number and company information below for the policy being replaced.

Policy Number	Company Name	Address	City	State	Zip

**7 INSURANCE NOW IN FORCE OR APPLIED FOR**

List all policies currently in force or applied for on the **proposed insured** not described in Section 6. **If none, check here.** ☐

Company Name	Policy Number	Kind	Life Insurance Amount	Accidental Death Amount	Year Issued

**8 VERIFICATION OF STATE SIGNED**

The state in which I signed the application was: \_\_\_\_\_

**9 VERIFICATION OF THE DATE OF APPLICATION**

The date I signed the application was: \_\_\_\_\_

**10 FIELD REPRESENTATIVE'S CERTIFICATION**

The proposed applicant is the insured, unless an adult applicant (youth application) or an owner other than the proposed insured is designated. Submit replacement forms, if required.

1. Were you present when this application was signed? (If "No", submit a full explanation). . . . . ☐ Yes ☐ No
2. Does the proposed applicant have any existing life insurance or annuity contracts? . . . . . ☐ Yes ☐ No
3. Do you have knowledge or reason to believe that replacement of existing insurance or annuities was or may be involved? (If "Yes", submit replacement forms, if required) . . . . . ☐ Yes ☐ No
4. Did you see the proposed insured when this application was written? (If "No", submit a full explanation with the application). . . . . ☐ Yes ☐ No
5. I asked each question exactly as written and accurately recorded the information supplied in this application.

\_\_\_\_\_  
Field Representative's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Field Representative's Name Printed

**I have read the answers written above. I ratify and agree to be bound by such answers and agree that they are true and complete to the best of my knowledge and belief. I agree they shall form part of this application.**

*John K Woodmen*

Signature of Proposed Insured,  
if age 16 or older OR  
Signature of Proposed Adult Applicant

04/01/2010

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Proposed Applicant Owner  
if not Proposed Insured &  
Title if Trust/Corporation/Partnership

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Proposed Joint Applicant Owner  
& Title if Trust/Corporation/Partnership

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Proposed Joint Applicant Owner  
& Title if Trust/Corporation/Partnership

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Proposed Joint Applicant Owner  
& Title if Trust/Corporation/Partnership

\_\_\_\_\_  
Date

☒ **WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY**  
☐ **OMAHA WOODMEN LIFE INSURANCE SOCIETY**  
1700 Farnam Street Omaha, Nebraska 68102

CERTIFICATE NUMBER

UNDERWRITING  
SUPPLEMENTARY  
STATEMENT

Field Representative Code: 123456

☒ New Certificate ☐ Change Existing Certificate  
☐ Reinstatement ☐ Term Conversion

**PROPOSED INSURED (The insured is the applicant owner unless otherwise designated.)**

First John	Middle Initial K	Last Woodmen	Suffix
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Date of Birth (MM/DD/YYYY) 11/01/1974	Social Security Number 123-45-6789
--	---------------------------------------

**1 TOBACCO USAGE (Applies to proposed insured age 18 and over.)**

In the past **12 months**, has the proposed insured used tobacco/nicotine in any form, such as cigarettes, pipes, cigars, snuff or chewing tobacco OR smoking cessation products such as nicotine patches or nicorette gum? . . . . . ☐ Yes ☒ No

A. If "Yes", indicate date last used: mo. \_\_\_\_\_ yr. \_\_\_\_\_ Indicate form(s) used: \_\_\_\_\_

If cigarettes, how many packs per day? \_\_\_\_\_ If cigars, indicate quantity and frequency: \_\_\_\_\_

B. If "No", has the proposed insured used tobacco/nicotine in any form OR smoking cessation products in the last **36 months**? . . . . . ☐ Yes ☒ No

**2 OCCUPATION (Applies to proposed insured age 16 and over.)**

Occupation and Duties	Annual Income (Nearest \$10,000)	How Long in Present Occupation?
-----------------------	-------------------------------------	------------------------------------

Name of Employer and Nature of Business	Address of Business	Previous Occupation
---	---------------------	---------------------

**3 NONMEDICAL (Applies to proposed insured age 14 and over.)**

A. Does the proposed insured have a current driver's license/permit?

☐ No, explain why no license/permit: \_\_\_\_\_

☐ Yes, Driver's License/Permit Number: \_\_\_\_\_ State: \_\_\_\_\_

B. Is the proposed insured currently a United States citizen? If "No", provide permanent resident card number: ☐ Yes ☐ No

C. Has the proposed insured ever had a license/permit suspended or revoked? . . . . . ☐ Yes ☐ No

D. Has the proposed insured had any moving traffic violations or traffic accidents within the past three years? . . . . . ☐ Yes ☐ No

E. Has the proposed insured been convicted of or pled guilty or no contest to driving while intoxicated or under the influence of a narcotic drug? . . . . . ☐ Yes ☐ No

F. Has the proposed insured been convicted of or pled guilty or no contest to a crime within the past 10 years, or is the proposed insured currently awaiting trial for any crime? . . . . . ☐ Yes ☐ No

G. Is the proposed insured currently on probation or parole? . . . . . ☐ Yes ☐ No

H. Is the proposed insured a member of the U.S. Armed Services or active reserve? . . . . . ☐ Yes ☐ No

If "Yes", has the proposed insured been alerted of possible deployment? If "Yes", give details below. . . . . ☐ Yes ☐ No

**If any question C-H has been answered "Yes", give dates and full details:**

I. Within the next 12 months, does the proposed insured intend to travel or reside outside of the U.S., Canada or any U.S. territories? If "Yes", complete Section 6 on this form . . . . . ☐ Yes ☐ No

J. In the past 3 years has the proposed insured participated in aviation as a pilot, crew member or student – to include sky diving, hang gliding, ballooning, ultralight, and other sky sports – or intends to within the next 2 years? If "Yes", submit an Aviation Questionnaire . . . . . ☐ Yes ☐ No

K. In the past 3 years has the proposed insured participated in racing of any type, skin or scuba diving, boxing, ultimate fighting or mountain climbing – or intends to within the next 2 years? If "Yes", submit an Avocation Questionnaire . . . . . ☐ Yes ☐ No

**4 YOUTH INFORMATION (Applies to proposed insured age 0-15.)**

- A. Does the child live with the natural or adoptive parent(s)? . . . . . ☐ Yes ☐ No  
If "No", explain why \_\_\_\_\_
- B. Does the child have brothers and/or sisters? ☐ Yes ☐ No (If "Yes", indicate amount of coverage carried on each child and their ages.)  
\_\_\_\_\_
- C. Indicate amount of insurance carried by Father \$ \_\_\_\_\_  
Indicate amount of insurance carried by Mother \$ \_\_\_\_\_

**5 FAMILY HISTORY (Applies to proposed insured.)**

- A. Has a parent or sibling been diagnosed or treated by a member of the medical profession for cardiovascular disease or cancer prior to age 60? . . . . . ☐ Yes ☐ No  
If "Yes", give details \_\_\_\_\_
- B. Did death of a parent or sibling occur prior to age 60 due to cardiovascular disease or cancer? . . . . . ☐ Yes ☐ No

**6 TRAVEL (Applies to proposed insured age 16 and over.)**

Please provide the following details for any travel plans you have to locations other than the United States (and its territories or Canada):

1. What country, or countries, do you plan on traveling to? \_\_\_\_\_
2. What city or cities do you plan to visit? \_\_\_\_\_
3. When do you plan on going? \_\_\_\_\_
4. How long do you plan on being there? \_\_\_\_\_
5. What is the purpose of the trip? \_\_\_\_\_
6. Will medical and sanitation facilities be accessible? \_\_\_\_\_

**Provide any additional information relating to the above questions that would be helpful in consideration of the application.**

**I have read the answers written above. I ratify and agree to be bound by such answers and agree that they are true and complete to the best of my knowledge and belief. I agree they shall form part of this application.**

<u><i>John K Woodmen</i></u>	<u>04/01/2010</u>
Signature of Proposed Insured, if age 16 or older OR Signature of Proposed Adult Applicant	Date



☒ **WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY**  
☐ **OMAHA WOODMEN LIFE INSURANCE SOCIETY**  
1700 Farnam Street Omaha, Nebraska 68102

CERTIFICATE NUMBER

AVIATION  
QUESTIONNAIRE

Field Representative Code: 123456

☒ New Certificate ☐ Change Existing Certificate  
☐ Reinstatement ☐ Term Conversion

**PROPOSED INSURED (The insured is the applicant owner unless otherwise designated.)**

First John Middle Initial K Last Woodmen Suffix

Date of Birth (MM/DD/YYYY) 11/01/1974

Social Security Number 123-45-6789

**Questions 1-6 apply to the Proposed Insured.**

1. TYPE OF FLYING	Total Lifetime Solo Hours Per Category	Hours as Pilot or Co-pilot		
		Past 12 Months	Past 13-24 Months	Estimated next 12 Months
COMMERCIAL (Flying for pay)				
Scheduled passenger airline. . . . .				
Corporate owned aircraft for employee transportation . .				
Crop Dusting . . . . .				
Other freight carrying or passenger service . . . . .				
Student instruction . . . . .				
Other (airshow, crew member, forestry service, etc.) Explain in No. 6 below.				
NON-COMMERCIAL (Not flying for pay)				
Pleasure . . . . .	300	35	0	0
Personal business transportation . . . . .				
Instruction as a student. . . . .				
Other (e.g., helicopter, glider, ultralight, hang gliding, sky diving, ballooning) Explain in No. 6 below.				

2. If you haven't flown in the last two years, do you intend to fly in the future? ☐ Yes ☒ No If "Yes", explain in No. 6 below.

3. Have you ever had an aircraft accident, or been grounded, fined or reprimanded for violation of air regulations? ☐ Yes ☒ No  
If "Yes", explain in No. 6 below.

**4. WITH RESPECT TO CIVILIAN FLYING**

What type(s) of certificate or license do you have? ☐ Student ☐ Commercial ☒ Private ☐ ATR ☐ IFR

If IFR, how many SOLO hours of instrument time have you flown in the past 12 months? \_\_\_\_\_

Have you flown, or do you intend to fly outside the U.S.? ☐ Yes ☒ No If "Yes", explain in No. 6 below.

What type of aircraft do you fly? ☐ Single engine ☒ Multi-engine

Do you engage in or do you contemplate engaging in any type of flying not indicated above? ☐ Yes ☐ No  
If "Yes", explain in No. 6 below.

**5. WITH RESPECT TO MILITARY FLYING**

A. Specify capacity in which you fly: ☐ Pilot ☐ Co-Pilot ☐ Navigator ☐ Crew

HOURS FLOWN Total Hours: \_\_\_\_\_ Past 12 months: \_\_\_\_\_ Contemplated next 12 months: \_\_\_\_\_

B. To what type of military organization do you belong? ☐ Army ☐ Navy ☐ Air Force ☐ Marines ☐ ROTC  
☐ National Guard/Reserves ☐ Other Explain in No. 6 below.

C. What type of aircraft do you fly in? (Specify alphabetic and numeric code, e.g., B-1) \_\_\_\_\_

D. Do you fly from an aircraft carrier? ☐ Yes ☐ No

**6. DETAILS (Specify Question Number):**

7. Based on full analysis of the information provided above, an extra premium rate may be assessed. You have the option to choose to pay the extra premium or accept coverage exclusion/limitations for aviation risks. Which option do you select?

A. ☒ Extra Rate

B. ☐ Coverage exclusion/limitations for aviation risks

**I have read the answers written above. I ratify and agree to be bound by such answers and agree that they are true and complete to the best of my knowledge and belief. I agree they shall form part of this application.**

*John K Woodmen*

04/01/2010

Signature of Proposed Insured,  
if age 16 or older OR  
Signature of Proposed Adult Applicant

Date

Signature of Proposed Applicant Owner  
if not Proposed Insured &  
Title if Trust/Corporation/Partnership

Date

Signature of Proposed Joint Applicant Owner  
& Title if Trust/Corporation/Partnership

Date

Signature of Proposed Joint Applicant Owner  
& Title if Trust/Corporation/Partnership

Date

Signature of Proposed Joint Applicant Owner  
& Title if Trust/Corporation/Partnership

Date

☒ **WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY**  
☐ **OMAHA WOODMEN LIFE INSURANCE SOCIETY**  
**1700 Farnam Street Omaha, Nebraska 68102**

Field Representative Code: 123456

CERTIFICATE NUMBER

AVOCATION  
QUESTIONNAIRE

☒ New Certificate ☐ Change Existing Certificate  
☐ Reinstatement ☐ Term Conversion

**PROPOSED INSURED (The insured is the applicant owner unless otherwise designated.)**

First John Middle Initial K Last Woodmen Suffix \_\_\_\_\_

Date of Birth (MM/DD/YYYY)

11/01/1974

Social Security Number

123-45-6789

**1 RACING SPORTS**

TYPE: ☐ Drag ☐ Indy Car ☐ Kart ☐ Midget ☐ Formula ☐ GT ☐ Rally ☐ Production ☐ Sprint ☐ Stock ☐ Motorcycle ☐ Boat ☐ Other \_\_\_\_\_ Vehicle Category \_\_\_\_\_  
Racing Division \_\_\_\_\_  
Make: \_\_\_\_\_ Model: \_\_\_\_\_ Engine Displacement: \_\_\_\_\_  
Horsepower: \_\_\_\_\_ Type of Fuel: \_\_\_\_\_ Highest attained speed during race \_\_\_\_\_ mph.  
Through what organization is vehicle sanctioned? \_\_\_\_\_ In what class do you race? \_\_\_\_\_  
Track: ☐ Oval Track ☐ Closed Circuit ☐ Drag Strip ☐ Hill Climb ☐ Other: \_\_\_\_\_ Track Length \_\_\_\_\_  
Yrs. of experience \_\_\_\_\_ Number of races last 12 mos. \_\_\_\_\_ Avg. length of race \_\_\_\_\_ Number of races next 12 mos. \_\_\_\_\_

**2 SCUBA DIVING**

TYPE: ☒ Open Water ☐ Photography ☐ Spear Fishing ☐ Cave ☐ Salvage/Treasure ☐ Wreck diving with penetration

Depth →	To 75 Ft.	76-100 Ft.	101-130 Ft.	OVER 130 Ft.	Avg. time under water per dive
No. of dives next 12 months	<u>7</u>				
No. of dives past 12 months	<u>6</u>				
No. of dives in previous 13-24 months	<u>7</u>				

Have you received one of the following National Certifications? ☐ PADI ☐ NAUI ☐ NASDS ☐ YMCA  
Have you received one of the following diving certifications: ☐ Diving with an instructor ☐ Basic Cert. ☒ Open Water Cert.  
☐ Adv. Open Water Cert. ☐ Specialty Course Cave ☐ Specialty Course Wreck ☐ Specialty Course Other \_\_\_\_\_  
☐ Dive Master Cert. ☐ Ass't. Instructor or Instructor ☐ Master Instructor ☐ Master Scuba Diver  
If diving over 75 ft., please describe location, type of dive and if it was supervised: \_\_\_\_\_  
Do you use the buddy system? ☐ Yes ☒ No Location of dives: ☐ Oceans ☐ Pools ☒ Lakes/Rivers ☐ Bays/Inlets

**3 BOXING, ULTIMATE FIGHTING**

1. Please identify which of the activities you participate in:

☐ Ultimate Fighting  
☐ Boxing Type: ☐ Golden Glove ☐ Olympic ☐ Championship ☐ Other (Explain in No. 3 below)

2. Number of fights: Last 12 mos. \_\_\_\_\_ Past 13-36 mos. \_\_\_\_\_ Est. next 12 mos. \_\_\_\_\_

3. Details:

**4 MOUNTAIN CLIMBING**

How many years of experience climbing do you have? \_\_\_\_\_ How many times per year do you climb? \_\_\_\_\_  
Usual duration of climb? Hours: \_\_\_\_\_ Days: \_\_\_\_\_ Average Height? \_\_\_\_\_  
Have you had any climbing accidents? ☐ Yes ☐ No Do you plan on climbing outside the U.S.? . . . . . ☐ Yes ☐ No  
Do you climb alone? ☐ Yes ☐ No Is the insurance coverage being used to cover any type of climbing event? ☐ Yes ☐ No  
For any "Yes" answers in Section 4, please explain (regarding nature, location, frequency and degree of participation).

**I have read the answers written above. I ratify and agree to be bound by such answers and agree that they are true and complete to the best of my knowledge and belief. I agree they shall form part of this application.**

John K Woodmen

Signature of Proposed Insured, if age 16 or older  
OR Signature of Proposed Adult Applicant

04/01/2010

Date

PROPOSED INSURED (The insured is the applicant owner unless otherwise designated)

First	Middle Initial	Last	Suffix
John	K	Woodmen	

Date of Birth (MM/DD/YYYY)	Social Security Number
11/01/1974	123-45-6789

**All questions apply to the proposed insured.**

1. **ALCOHOL USAGE** For purposes of this questionnaire, **one drink is defined** as 12 oz. of beer, 4 oz. of wine or ½ oz. of pure alcohol.

- A. In the past 12 months, have you consumed alcoholic beverages? . . . . . ☐ Yes ☒ No

If "Yes", number of drinks consumed:      Daily \_\_\_\_\_ Weekly \_\_\_\_\_

Date of last drink: \_\_\_\_\_

- B. Past use - from 13 months to 8 years - have you consumed alcoholic beverages? . . . . . ☐ Yes ☒ No

If "Yes", number of drinks consumed: Weekly \_\_\_\_\_ Date of last drink: \_\_\_\_\_

## 2. DRUG USAGE

- A. Have you ever used IV (intravenous) drugs? . . . . . ☐ Yes ☒ No

- B. Except as prescribed by a licensed health professional, have you within the past eight (8) years used or do you currently use any of the following? Give details below to all "Yes" answers.

1. Marijuana (e.g., Hashish, Cannabis, THC) . . . . . ☒ Yes ☐ No

2. Amphetamines, Stimulants (e.g., Cocaine, Speed, Methamphetamine, etc.), Hallucinogens (e.g., LSD, PCP, etc.), Sedatives or Barbiturates (e.g., Amytal, Librium, Valium, etc.), Opiates or Narcotics (e.g., Heroin,

- Morphine, Methadone, etc.) or Other (e.g., glue, ether, paint thinners). . . . . ☐ Yes ☒ No

Name of Drug	Usual Quantity	Frequency of Use Daily, Weekly, Monthly	Dates	
			From:	To:
Marijuana		Monthly	06/01/2005	09/01/2008

### 3. ADDITIONAL INFORMATION

- A. In the past eight (8) years have you consulted with or been advised by a physician or other health care provider to **reduce alcohol or drug intake**, to **seek treatment** or to **go to a counseling or support group**? . . . . . ☐ Yes ☒ No

If "Yes", mark the box and give details: ☐ Drugs ☐ Alcohol ☐ Both

1. Date(s)

- ## 2. Details

3. Name & address of physician/clinic

- B. Have you ever been treated for alcoholism or drug abuse? . . . . . ☐ Yes ☒ No

If "Yes", mark the box and give details: ☐ Drugs ☐ Alcohol ☐ Both

1. Date(s)

2. Number/length of treatment(s)

- 
3. Name & address of facility

- C. Have you ever been convicted of driving while under the influence of alcohol or drugs; been convicted for the use, possession or trafficking of any drug; or been convicted of a crime as a result of the use of alcohol or drugs? . . . ☐ Yes ☒ No

If "Yes", mark the box and give details: ☐ Drugs ☐ Alcohol ☐ Both

1. Date(s) of conviction(s)

2. County & state of conviction(s)

3. Date sentence/probation was completed

**I have read the answers written above. I ratify and agree to be bound by such answers and agree that they are true and complete to the best of my knowledge and belief. I agree they shall form part of this application.**

John K Woodmen

Signature of Proposed Insured, if age 16 or older  
OR Signature of Proposed Adult Applicant

04/01/2010

---

Date

**WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY  
HOME OFFICE - OMAHA, NEBRASKA**

**INSURED** [JOHN X WOODMEN]

**OWNER(S)/CONTROLLER** as named in the application

**EFFECTIVE DATE** [JULY 1, 2010]

**CERTIFICATE** [123456789]

**RATIFICATION OF CHANGE IN COVERAGE APPLIED FOR AND/OR APPLICATION DATED** [date application signed]

1 I hereby agree to the following changes in certificate [123456789]

2 [The waiver rider has not been included on this certificate.]

3 **[IMPORTANT]** - If this form is signed and the required premium has been paid, this certificate will be in force as of the date shown on the certificate, or as of the date this form is signed, whichever comes first. In any event, this form must be signed not later than [August 1, 2010] and returned to the Home Office or the certificate will be canceled.]

If this form is signed, it will be on file. You may request a copy from the Home Office.

- signature(s) required on reverse side -

4

I understand and agree that the foregoing changes are made part of the application and of the certificate issued thereunder. These changes shall be binding on any person who shall have or claim any interest under such certificate.

**SIGNATURE OF OWNER(S)/CONTROLLER**

[JOHN X WOODMEN]

- \_\_\_\_\_

[

- \_\_\_\_\_ ]

[

- \_\_\_\_\_ ]

[

- \_\_\_\_\_ ]

[

- \_\_\_\_\_ ]

**SIGNATURE OF FIELD REPRESENTATIVE**

- \_\_\_\_\_

**DATE**

- \_\_\_\_\_

SERFF Tracking Number: WDM-126590160 State: Arkansas

Filing Company: Woodmen of the World Life Insurance Society State Tracking Number: 45598

Company Tracking Number: LIFE APPS 5055 R-3/10, 601 R-3/10, 943 R-3/10, 956 R-3/10, 835 R-3/10, 836 R-3/10, 7692 R-3/10, RATIFICATION 8217 3-10

TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other

Product Name: Life App 5050 R-3/10 & Related Forms

Project Name/Number: /

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status</b>
		<b>Date:</b>
<b>Satisfied - Item:</b> Flesch Certification		
<b>Comments:</b>		
<b>Attachments:</b>		
Readability Ctf. App..pdf		
Rule & Reg 19 Ctf. Apps.pdf		

	<b>Item Status:</b>	<b>Status</b>
		<b>Date:</b>
<b>Satisfied - Item:</b> Application		
<b>Comments:</b>		
Applications are new and are listed under the Form Schedule tab.		

	<b>Item Status:</b>	<b>Status</b>
		<b>Date:</b>
<b>Satisfied - Item:</b> Statement of Variability for Ratification 8217 3-10		
<b>Comments:</b>		
<b>Attachment:</b>		
8217 3-10 Rat Variability.pdf		

**WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY**  
**1700 Farnam Street, Omaha, Nebraska 68102-2007**

**FLESCH CERTIFICATION**

<u><b>Form Number(s)</b></u>	<u><b>Description</b></u>	<u><b>Flesch Score</b></u>
Form 5055 R-3/10	Application for Life Insurance with Child Benefits and Membership	50.4
Form 601F 10/08	Term Life Insurance with Child Benefits Adult Medical Supplementary Statement	51
Form 943F 10/08	Term Life Insurance with Child Benefits Administrative Supplementary Statement	52.3
Form 956F 10/08	Term Life Insurance with Child Benefits Underwriting Supplementary Statement	58.7
Form 8079F 10/08	Term Life Insurance with Child Benefits Children's Supplementary Statement	51
Form 835F 10/08	Term Life Insurance with Child Benefits Aviation Questionnaire	69.3
Form 836F 10/08	Term Life Insurance with Child Benefits Avocation Questionnaire	52.9
Form 7692F 10/08	Term Life Insurance with Child Benefits Alcohol & Drug Questionnaire	53.2
Form 8070 10-08	Ratification Form	61.3

I certify that these Flesch Index numbers are accurate in accordance with the published rules of application of the test.

---

Randall P. Rotschafer  
Vice President and Chief Actuary



WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY  
1700 Farnam Street, Omaha, Nebraska 68102

CERTIFICATION

I certify that to the best of my knowledge and belief the form(s) in this submission meets the provisions of Rule and Regulation 19 as well as all applicable requirements of the Arkansas Insurance Department.

May 5, 2010

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Date

---

Vice President & Chief Actuary

Form(s):

FORM 5055 R-3/10

601 R-3/10

943 R-3/10

956 R-3/10

835 R-3/10

836 R-3/10

7692 R-3/10

8217 3-10

## **Statement of Variability**

**The following is the statement of variability for Form 8217 3-10 which will be attached to the certificate if one or more of the following situations apply.**

### **Section 1: One of the following statements will print:**

“I hereby agree to the following changes in certificate [123456789]”

“I hereby agree to the following increase in Benefit Amount.”

“I hereby agree to the following increase in Face Amount.”

### **Section 2: One of the following statements will print:**

The waiver rider has been issued at a special class rate on this certificate or increase. This special rating class will increase premiums on traditional life plans or the cost of insurance on universal life plans.

The waiver rider has not been included on this certificate or increase.

The waiver rider has been changed or added to this certificate or increase. Please see the certificate rider for details.

The Accidental Death Benefit Rider has been issued at a special class rate on this certificate or increase. This special rating class will increase premiums on traditional life plans or the cost of insurance on universal life plans.

The Accidental Death Benefit Rider has not been included on this certificate or increase.

The Accidental Death Benefit Rider has been changed or added to this certificate or increase. Please see the certificate rider for details.

The Additional Insurance Option Rider has not been included in this certificate or increase.

The Additional Insurance Option Rider has been changed or added to the certificate or increase. Please see the certificate rider for details.

The Guaranteed Insurability Rider has not been included in this certificate.

The Guaranteed Insurability Rider amount has been changed or the rider has been added to the certificate. Please see the certificate rider for details.

The Applicant Waiver Rider has not been included in this certificate or increase.

The Applicant Waiver Rider has been changed or added to this certificate or increase. Please see the certificate rider for details.

The Accelerated Death Benefit Rider has not been included in this certificate or increase.

This certificate or increase has been issued at a special class rate. This special rating class will increase premiums on traditional life plans or the cost of insurance on universal life plans.

The face amount of insurance for this certificate or increase has been changed. The face amount on the copy of the application has been compared with the new face amount on the certificate or the amendment.

The kind of insurance for this certificate has been changed. The kind of insurance on the copy of the application has been compared with the new kind of insurance on the certificate.

The face amount of insurance for the term rider has been changed. The face amount on the copy of the application has been compared with the new face amount on the term rider.

The kind of insurance for the term rider has been changed. The kind of insurance on the copy of the application has been compared with the new kind of insurance on the term rider.

The term rider has not been included in this certificate.

The cash surrender value will be included in the face amount of insurance.

The cash surrender value will be excluded from the face amount of insurance.

The age for this certificate or increase has been changed.

The Automatic Premium Loan provision has been included in this certificate.

The Automatic Premium Loan provision has not been included in this certificate.

The face amount of insurance for this increase has been issued at a special class rate because of a change in the tobacco rating class. This change will increase the cost of insurance for the increase in face amount.

I understand this certificate has been issued with a tobacco rating class based on the underwriting findings. This classification will increase premiums on traditional life plans or the cost of insurance on universal life plans. It may also affect any refunds.

I understand this certificate has been issued with a tobacco rating class based on the underwriting findings. This classification will increase premiums on traditional life plans or the cost of insurance on universal life plans. It may also affect any refunds and cash values.

I understand that Certificate \_\_\_\_\_ has been exchanged for this certificate; and Certificate \_\_\_\_\_ was issued at a preferred rating class. I further understand that a preferred rating class is not available for this certificate and that this certificate has been issued at a standard rating class which is the best mortality rating available for this product.

The application did not specify a planned premium or the planned premium has been increased. To meet minimum premium requirements, this certificate has been issued with a planned premium of \$\_\_\_\_\_.

The planned premium has been changed on this certificate or increase.

The application did not specify an available certificate anniversary age to which planned premiums are payable. This certificate has been issued with planned premiums payable to the certificate anniversary following age 80.

The application did not specify an available certificate anniversary age to which planned premiums are payable. This certificate has been issued with planned premiums payable to the certificate anniversary following age 100.

The application did not specify an available certificate anniversary age to which planned premiums are payable. This certificate has been issued with planned premiums payable to the certificate anniversary following age 120.

The age at which this certificate has been issued has been changed to \_\_\_\_\_.

The Daily Benefit Amount of this certificate has been changed to \_\_\_\_\_.

The Benefit Period of this certificate has been changed to \_\_\_\_\_.

The Elimination Period of this certificate has been changed to \_\_\_\_\_.

If the premium paid at issue or at any time thereafter would cause the certificate to be classified as a modified endowment contract (MEC) because the premium exceeds the amount allowed by the Internal Revenue Code (IRC), I choose to allow the certificate to become a MEC (excess premium is added to the certificate). I understand that distributions from MECs do not have the benefit of the favorable tax rules that typically apply to lifetime distributions from other life insurance contracts and that distributions are subject to a penalty tax unless certain exceptions apply, such as attaining age 59-1/2. Woodmen has advised me to contact my professional tax advisor for advice about the tax consequences of owning a MEC.

If the premium paid at issue or at any time thereafter would cause the certificate to be classified as a modified endowment contract (MEC) because the premium exceeds the amount allowed by the Internal Revenue Code (IRC), I do not want my certificate to be a MEC. Instead, I choose to place any premiums that would cause an IRC 7-Pay Test failure into the "Advance Premium Fund". I approve the transfer of money from the Advance Premium Fund to the value of my certificate at the beginning of each certificate year. I understand that the amount transferred will not exceed the amount allowed under the IRC 7-Pay Test based on Woodmen's interpretation of the requirements of the 7-Pay Test.

**Section 3: One of the following statements will print:**

**"IMPORTANT** - If this form is signed and the required premium has been paid, this certificate will be in force as of the date shown on the certificate, or as of the date this form was signed, whichever comes first. In any event, this form must be signed not later than [August 1, 2010] and returned to the Home Office or the certificate will be canceled."

**"IMPORTANT** - If this form is signed and the required premium has been paid, this increase will be in force as of the date shown on the certificate amendment, or as of the date this form was signed, whichever comes first. In any event, this form must be signed not later than [August 1, 2010] and returned to the Home Office or the increase will be canceled."

**"IMPORTANT** - If this form is signed and the required premium has been paid this certificate will be in force as of the date shown on the certificate, or as of the date this form was signed, whichever comes first. This certificate was issued upon exchange or conversion for one or more certificates issued by Woodmen, and coverage under the exchanged or converted certificate(s) continues until this ratification form is signed, but will automatically cease when coverage under this certificate starts. In any event, this form must be signed not later than [August 1, 2010] and returned to the Home Office or the certificate will be cancelled, and the certificate(s) exchanged or converted will continue according to the terms of the certificates as though no exchange or conversion had occurred."

**"IMPORTANT** - If this form is signed and the required premium has been paid this increase will be in force as of the date shown on the certificate amendment, or as of the date this form is signed, whichever comes first. This increase was issued upon exchange or conversion for one or more certificates issued by Woodmen, and coverage under the exchanged or converted certificate(s) continues until this ratification form is signed, but will automatically cease when coverage under this increase starts. In any event, this form must be signed not later than [August 1, 2010] and returned to the Home Office or the increase will be cancelled, and the certificate(s) exchanged or converted will continue according to the terms of the certificates as though no exchange or conversion had occurred."

**Section 4: One of the following statements will print:**

"I understand and agree that the foregoing changes are made part of the application and of the certificate issued thereunder. These changes shall be binding on any person who shall have or claim any interest under such certificate."

"I understand and agree that the foregoing changes are made part of the application and of the increase issued thereunder. These changes shall be binding on any person who shall have or claim any interest under such certificate."